Facilty A Discharge/ Transfer

ASSISTANCE TO RESIDENTS IN COUNTY HOMES / ROOM AND BOARD ASSISTANCE BUDGET AND RECOMMENDATION

State Form 31759 (R2 / 5-96) / BAIS 0005B

Name of county: St Joseph Co. 71

Name of applicant / recipient (*first, middle, last*)	Case number	Social Security number
JANE Doe	MD71000001	000-00-0000

Home address (*number and street, city,state, ZIP code*): 118 S. Williamstreet South Bend Indiana 46601

Name of spouse of applicant / recipient: NA

Is the spouse an applicant / recipient of ARCH / RBA? ☐ Yes ☒ No

Address of spouse of applicant / recipient (*number and street, city, state, ZIP code*): NA

Name of ARCH / RBA facility: MADISON Center Inc. DBA The manor

ARCH / RBA facility address (*number and street, city, state, ZIP code*): 118 S William Street South Bend mdiana 46601

Name of guardian or responsible person: NA

Guardian's address (*number and street, city, state, ZIP code*): NA

Date budget computed (*Add "D" for desk review only*)	HIB number	Name of health insurance company	Policy number
DR	-0-	medicaid	XXXXX

RECOMMENDATION AND COUNTY DIRECTOR'S ACTION

Application date	Date entered ARCH / RBA facility	ARCH / RBA effective date

☐ **APPROVED**

ARCH / RBA AWARD	ARCH / RBA LIABILITY	EFFECTIVE DATE
$	$	
$	$	
$	$	
$	$	

☐ **DENIED**

EFFECTIVE DATE 10-5-8

☐ **CONTINUED** ARCH / RBA liability $

☒ **DISCONTINUED** 10-5-08

☐ **SUSPENDED UNTIL** .....

Reason for adverse action: Discontinued-Partial Month Transfer To West Park Health Care facilities on 10-6-8

Payment to facility A For 5 days 49.35 x 5 = 246.75 Facility B 914.25

MEDICAID INFORMATION

EFFECTIVE DATE	ACTION
	☐ **APPROVED**
	☐ **DENIED** Reason for denial: _____
	☐ **CONTINUED**
	☐ **DISCONTINUED** Reason for discontinuance: _____

Legal citation

Signature of caseworker	Date signed
X	X

Signature of director	Date signed
X	X

(*Continued on the reverse side*)

Facility A Discharge/Transfer

BUDGET COMPUTATION	
1. Unearned Income of Applicant / Recipient (A / R)	$
2. Net earned income of A / R (From Table 2)	+
3. Deemed income of ineligible spouse (Line 6 from Table 1)	+
4. TOTAL (Lines 1 and 2 or 1, 2 and 3)	$
5. Personal Needs Allowance	
6. Liability (Subtract Line 5 from Line 4)	$
7. Subtract ARCH / RBA rate	-
8. Deficit	
9. Surplus	
10. ARCH / RBA Award	$

TABLE 1 - DEEMED INCOME OF INELIGIBLE SPOUSE	
1. Countable income of ineligible spouse	$
2. Subtract personal needs allowance	-
3. Subtract ARCH / RBA rate	-
4. Surplus income of ineligible spouse	=
5. Subtract ineligible spouse's medical expenses	-
6. Deemed income to eligible spouse	=

TABLE 2 - DETERMINATION OF NET EARNINGS	A	B	C
1. Name(s)			
2. Gross earnings	$	$	$
3. Expenses (List as applicable)			
4. Total expenses	$	$	$
5. Net earnings	$	$	$

VERIFICATIONS AND COMPUTATIONS

Partial Month Transfer To West Park Healthcare Facilities, LLC.

Facility A: 49.35 x 5 = 246.25

Facility B. 1161.00 - 246.25 = 914.25 To Transfer with recipient at Discharge

Facility B
Partial Month calculation
Full Month Calculation

ASSISTANCE TO RESIDENTS IN COUNTY HOMES / ROOM AND BOARD ASSISTANCE BUDGET AND RECOMMENDATION

State Form 31759 (R2 / 5-96) / BAIS 0005B

Name of county: St Joseph Co 71

Name of applicant / recipient (*first, middle, last*)	Case number	Social Security number
JANE DOE	M071000002	000-00-0000

Home address (*number and street, city,state, ZIP code*): 5024 WESTERN AVE. South Bend Indiana 46619

Name of spouse of applicant / recipient: NA

Is the spouse an applicant / recipient of ARCH / RBA? ☐ Yes ☑ No

Address of spouse of applicant / recipient (*number and street, city, state, ZIP code*): NA

Name of ARCH / RBA facility: WEST PARKE HEALTH CARE FACILITIES L.L.C

ARCH / RBA facility address (*number and street, city, state, ZIP code*): 5024 Western Ave. South Bend Indiana 46619

Name of guardian or responsible person: NA

Guardian's address (*number and street, city, state, ZIP code*): NA

Date budget computed (*Add "D" for desk review only*)	HIB number	Name of health insurance company	Policy number
OR	—	medicaid	XXXXX

RECOMMENDATION AND COUNTY DIRECTOR'S ACTION

Application date	Date entered ARCH / RBA facility	ARCH / RBA effective date
10-6-8	10-6-8	10-6-8

☐ **APPROVED**

ARCH / RBA AWARD	ARCH / RBA LIABILITY	EFFECTIVE DATE
$ 368.85	$ 914.25	10-6-8
$ 340.07	$ 1161.00	11-1-08
$	$	
$	$	

☐ **DENIED** — EFFECTIVE DATE: 10-6-8

☐ **CONTINUED** — ARCH / RBA liability: $

☐ **DISCONTINUED**

☐ **SUSPENDED UNTIL** .....

Reason for adverse action: ACTIVE TRANSFER from Madison Center on 10-6-8

Partial month Payment 914.25
(1) 986.25 - 5200 = 914.25 10/6/8
(2) Full month payment effective 11/1/8

MEDICAID INFORMATION

EFFECTIVE DATE	ACTION
	☐ **APPROVED**
	☐ **DENIED** Reason for denial:
	☐ **CONTINUED**
	☐ **DISCONTINUED** Reason for discontinuance:

Legal citation:

Signature of caseworker	Date signed
X	X

Signature of director	Date signed
X	X

(*Continued on the reverse side*)

Facility B
Partial Month/ Full Month

Per Day Rate
10-6-8

365 Day Ratio
11-1-8

BUDGET COMPUTATION			
1. Unearned Income of Applicant / Recipient (A / R)	10-6-8	966.25	$ 1213.00
2. Net earned income of A / R (From Table 2)		0	+ 0
3. Deemed income of ineligible spouse (Line 6 from Table 1)		0	+ 0
4. TOTAL (Lines 1 and 2 or 1, 2 and 3)		966.25	$ 1213.00
5. Personal Needs Allowance	52.00	52.00	
6. Liability (Subtract Line 5 from Line 4)		914.25	$ 1161.00
7. Subtract ARCH / RBA rate		1283.10	- 1501.07
8. Deficit		-368.85	-340.07
9. Surplus			
10. ARCH / RBA Award		368.85	$ 340.07

TABLE 1 - DEEMED INCOME OF INELIGIBLE SPOUSE	
1. Countable income of ineligible spouse	$
2. Subtract personal needs allowance	-
3. Subtract ARCH / RBA rate	-
4. Surplus income of ineligible spouse	=
5. Subtract ineligible spouse's medical expenses	-
6. Deemed income to eligible spouse	=

TABLE 2 - DETERMINATION OF NET EARNINGS	A	B	C
1. Name(s)			
2. Gross earnings	$	$	$
3. Expenses (List as applicable)			
4. Total expenses	$	$	$
5. Net earnings	$	$	$

VERIFICATIONS AND COMPUTATIONS

10-6-8 Partial Month

49.35 x 26 = 1283.10

966.25
-52.00
914.25 Liability

-914.25 Liability
-368.85 Deficit

Full Month:

49.35 x 365 ÷ 12 = 1501.07 Full Month RBA RATE

1213.00 - 52.00 = 1161.00

1161.00 Liability
-1501.07 RBA RATE
340.07 Deficit